



**ADVANCED PRACTITIONER APPLICATION** Handwritten and / or Incomplete Applications will not be accepted. Scanned PDF preferred.

APPLICANT INFORMATION			
Last Name	First	M.I.	Date
Street Address		Apartment/Unit #	
City	State	Zip	
Professional/Nursing License Number		E-mail Address	
Date of Birth	Social Security Number	Gender	<input type="checkbox"/> M <input type="checkbox"/> F
Program Name		Graduation Date	
Home Phone		Mobile Phone	
Emergency Contact	Relationship	Phone	

SPECIALTY	
<input type="checkbox"/> Advanced Registered Nurse Practitioner (ARNP)	<input type="checkbox"/> Physician Assistant (PA)
<input type="checkbox"/> Certified Nurse Midwife (CNM)	<input type="checkbox"/> Certified Registered Nurse Anesthetist (CRNA)

NAME OF PRECEPTOR	APPROVED DATES OF TRAINING	
Practitioner	Start Date	End Date

TRAINING STATEMENT
Are you aware of any limitations that would prevent you from performing the duties required for the training you are requesting?
<input type="checkbox"/> No <input type="checkbox"/> Yes Please explain:

REQUIRED DOCUMENTATION (APPLICATIONS SUBMITTED WITHOUT THE REQUIRED DOCUMENTS WILL NOT BE CONSIDERED)	
<input type="checkbox"/> LETTER OF GOOD STANDING	<input type="checkbox"/> PROOF OF MALPRACTICE LIABILITY INSURANCE*
<input type="checkbox"/> BACKGROUND SECURITY CHECK*	<input type="checkbox"/> PROOF OF PERSONAL HEALTH INSURANCE*
<input type="checkbox"/> CURRICULUM VITAE	<input type="checkbox"/> TUBERCULOSIS SCREENING (PPD) ** – ANNUAL REQUIREMENT
<input type="checkbox"/> MEDICAL LICENSE (IF APPLICABLE)	<input type="checkbox"/> RESPIRATORY MASK FIT CERTIFICATE** (Required, however, students requiring mask fit testing can do so at FH)
<input type="checkbox"/> COPY OF PHOTO ID	<input type="checkbox"/> PROOF OF IMMUNIZATIONS - MMR Vaccination - Varicella Vaccination or Immunity and Hepatitis B (If refused, you must provide a signed wavier)

**\*THIS DOCUMENT CAN BE COMPILED IN THE LETTER OF GOOD STANDING OR A LETTER OF ATTESTATION**  
**\*\*THIS DOCUMENTATION IS AN ANNUAL REQUIREMENT**

SCHOOL/PROGRAM CONTACT INFORMATION OFFICIAL DESIGNATED TO RECEIVE CORRESPONDENCE/ EVALUATION		
Last Name	First	Title
Street Address		Suite/Unit #
City	State	Zip
E-mail Address		
Business Phone		Business Fax

DISCLAIMER AND SIGNATURE	
I certify that my answers are true and complete to the best of my knowledge. If this application is approved, I understand that I am responsible for submitting all required documents, as indicated in this application, including any additional documents as requested by the Florida Hospital GME Office.	
Signature	Date

PRECEPTOR INFORMATION <input type="checkbox"/> Independent <input type="checkbox"/> Dependent (If dependent this form requires the signature of the Supervising Physician)	
I am credentialed to practice at Florida Hospital. I have a valid affiliation agreement with the designated academic institution. I am approved to precept students from this program. I agree to allow the students to complete the requested rotations. I assume full responsibility for the conduct and actions of the students while on rotation.	
I understand that any false or misleading statement made on my application may be grounds for denial of this application. I hereby certify that the foregoing information is true and correct.	
Practitioner Last Name	First M.I.
Physician Last Name	First M.I. <input type="checkbox"/> MD <input type="checkbox"/> DO
Street Address	Suite/Unit # City State Zip
Business Phone	Business Fax Email
Signature, Practitioner	Date
Signature, Supervising Physician	Date

DATES APPROVED	
Start Date	End Date

ADVANCED PRACTITIONER APPLICATION STATUS (FOR GME ADMINISTRATIVE USE ONLY)		
The applicant is:	<input type="checkbox"/> Approved	<input type="checkbox"/> Declined
<input type="checkbox"/> Program Affiliation Agreement	<input type="checkbox"/> Required Documents on File	<input type="checkbox"/> GME Orientation Date

Signature, Director of Graduate Medical Education	Date
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**Submit Documentation to: Florida Hospital Graduate Medical Education**

Attention: GME Clerkship Coordinator  
 2501 North Orange Avenue, Suite 235  
 Orlando, Florida 32804  
 E-mail: [fh.gme.clerkship@flhosp.org](mailto:fh.gme.clerkship@flhosp.org)  
 Fax: 407.303.7323